***Sample Report Only***

# Indiana Medicaid:
# ACS Quarterly Report 3Q 2006

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# Indiana Medicaid Executive Summary 3Q 2006

**Participation.** During the third quarter of 2006, the average number of eligible members in the program was 262,885. While the number of eligibles remained steady, the overall average percent utilization decreased from 41.63% to 40.76% when compared to the previous quarter. The greatest number of utilizers by age group continues to be the population from 21 to 44 years of age.

**Claim Statistics.** The average number of prescriptions per utilizing member stayed constant at 4.1. Over this same time period, the average expenditures per utilizer increased from $222.82 to $224.33. When comparing to the previous quarter, the per eligible member per month (PMPM) decreased from $92.77 to $91.45. The average cost per claim increased from $53.94 to $54.48 over the previous quarter, while the average prescription count for the program increased to approximately 441 thousand.

**Medication Utilization.** In terms of prescription volume, the number of prescriptions for narcotic medications continued to surpass all other therapeutic classes. Atypical Antipsychotic medications remained the top therapeutic classes in terms of total amount paid. Novoseven is now the top individual agent by amount paid for the program.

Generic drug utilization increased 1% from second quarter 2006 to 66.60%. Brand utilization by amount paid remains substantially higher as compared to generic utilization. While 33.4% of the claims submitted were for brand products, these claims accounted for 83.45% of the total drug spend.

**Comments.** As part of the ongoing maintenance of the preferred drug list, ACS will be presenting full therapeutic class reviews in the first and second quarter of 2007, making recommendations based on new clinical and safety issues for existing PDL therapeutic classes.

The Retrospective Drug Utilization Review (RetroDUR) Program was unable to have an intervention approved due to lack of quorum at two of the DUR meetings. Two interventions were approved at the October meeting and will be performed in the fourth quarter.

The percent in drug spend in the mental health categories continues to remain high. Almost 40% of drug spend is in medications classified as AAAX. The State has undertaken steps to address this issue with the development of the MHQAC. The Committee has worked to identify issues related to mental health prescribing, and the first round of edits are set for a January 1st implementation. ACS is ready to implement changes or make recommendations that are in accordance with the guidelines set forth.

## Specific Intervention Recommendations and Potential Financial Impact

ACS has reviewed specific areas of the PDL performance, as well as general utilization trends. The following section describes actions that can result in cost-savings for OMPP through PDL or one of the current clinical programs ACS performs on behalf of OMPP. These efforts include an overview, a recommendation, and a potential savings estimate. Unless otherwise specified, all savings figures are total savings (not State-only funds). A table is provided at the end of the recommendations that includes total and State savings. This table assumes State savings are 25% of total savings.

## Provigil

**Overview.** A drug that shows high utilization, and has abuse potential, is Provigil. Provigil is indicated for narcolepsy and sleep apnea. When comparing the State's utilization data to other comparable Medicaid clients, Indiana has 3 times the utilization of Provigil as others. Implementation of prior authorization using the approved indications as criteria has shown a utilization decrease of 50% for this drug in other states.

**Recommendation.** Recommend requiring PA for Provigil, using narcolepsy or sleep apnea as required criteria.

**Potential Financial Impact.** Assuming a 40% conversion rate, the above interventions would result in approximately $510,000 in total savings per year.

| Date | Updates/Actions | Comments |
|---|---|---|
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## PDL: Proton Pump Inhibitors

**Overview.** PPIs have increasingly become maintenance drugs for many patients. Their use is perhaps fueled by direct-to-consumer advertising. Typically GERD can be controlled by an H2 antagonist, but may occasionally require use of a PPI short-term, if symptoms worsen. Peptic Ulcer Disease (PUD) may also require use of a PPI when there is an active ulcer, but acute therapy can also resolve the issue. Lifestyle modifications should be used to alleviate patient's symptoms as well. Hypersecretory conditions, such as Barrett's esophagus and Zollinger Ellison, may require twice daily dosing of a PPI for up to 12 months. The patient may then be re-evaluated to see if maintenance once-daily dose may appropriate.

**Recommendation.** ACS recommends two approaches to this therapeutic class. One is to limit usage of PPIs to 6 months for GERD and PUD patients. After 6 months, patients should be converted to H2 therapy. If the problems persist, this segment of patients could be authorized for an additional 6-month course of therapy, but only if there is documentation of lifestyle changes. Second, ACS recommends keeping authorization of twice daily dosing of PPIs for up to 12 months only for patients diagnosed with Barrett's or Zollinger-Ellison. Limiting PPI utilization would be a drastic change in the coverage currently available, but could potentially save substantial amounts by reducing unnecessary overutilization and indiscriminate use without harm to patients.

**Potential Financial Impact.** With prior authorization in place, a 20% conversion of PPI usage toward an H2 antagonist would result in $600 thousand dollars in savings per year. Even with 10% conversion, a potential total savings of $300 thousand dollars annually may be achieved.

| Date | Updates/Actions | Comments |
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## Tussionex

**Overview.** Tussionex is a cough suppressant that is widely abused and is costly to the state. When a patient needs a cough suppressant, there are many other alternatives equally effective at less than 20% of the price.

**Recommendation.** ACS recommends prior authorization of Tussionex. Approval should only be granted after documented failure of two other cough suppressants, and then the patient would only receive a maximum of a 10-day supply.

**Potential Financial Impact.** With an 80% conversion to other cough suppressants, the state could save $210 thousand dollars annually.

| Date | Updates/Actions | Comments |
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## Dose Optimization: Statins

**Overview.** Statins are used to treat high cholesterol. These products are indicated for once daily dosing and are available in multiple strengths with little variation between individual product's costs.

**Recommendation.** ACS recommends placing an edit in the claims processing engine to deny claims for more than one tablet per day of Lipitor 10mg, 20mg and 40mg; Lescol 20mg and 40mg; Lovastatin 10mg and 20mg; Pravastatin 10mg, 20mg, and 40mg; Crestor 5mg, 10mg and 20mg; Zocor 5mg, 10mg, 20mg and 40mg. This effort would be preceded by a RetroDUR initiative to convert patients to appropriate dosage regimens or issue any necessary authorizations before the POS edit took effect, or both.

**Potential Financial Impact.** Compliance with this effort should be approximately 60%. At this level, an estimated savings of $48,000 per year should be reasonable. If compliance were at 100%, the impact would be approximately $80,000.

| Date | Updates/Actions | Comments |
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## Sedative Hypnotics

**Overview.** Manufacturer's labeling state that sedative hypnotics should only be used for a period of seven to ten days. Many Indiana Medicaid recipients are using these products long-term (greater than 12 -24 months is common).

**Recommendations:** ACS recommends several approaches.

- Work with the DUR Board to remove sedative-hypnotics from the mental health cross-indicated drug list.
- Implement a max daily dose of 1 per day.(In August, approximately 300 recipients received more than 1 dose per day)
- An edit may be placed in the claims processing system that would only allow 15-days of therapy every 34 days. Any request for more than a 15-day supply would require a prior authorization. Since these medications are often inappropriately used for longer than 15 days, there may be a fair amount of provider push back.
- A RetroDUR effort would be an appropriate precursor to any hard edits placed in the system. This would allow prospective authorizations for patient whose prescriber deems it necessary to extend the recommended duration of therapy.

**Potential Financial Impact.** Assuming forty percent compliance with the therapy duration of not more than 15 days of therapy every 34 days would result in a savings of $600,000 per year.

## Supplemental Rebates for AAAX medication

**Overview.** AAAX medications currently are not reviewed under the State's current PDL, and therefore are not included in supplemental rebate negotiations.

**Recommendation.** ACS recommends consideration given to incorporate some of the major therapeutic classes (stimulants, atypical antipsychotics, sedative/hypnotics) into the State's PDL, allowing the state to solicit supplemental rebate bids on these products.

**Potential Financial Impact.** While a financial impact would depend on many factors, there may be potential for supplemental rebates of up to $1.5 million per quarter.

| Date | Updates/Actions | Comments |
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The table below presents a summary of the initiatives and savings listed above.

| Initiative | Program(s) | Total Savings | State Dollars |
|---|---|---|---|
| Provigil | PA/POS changes | $510,000 | $127,500 |
| PPIs | PDL/PA/POS edits | $600,000 | $150,000 |
| Tussionex | POS edits/ Prior Auth | $210,000 | $52,500 |
| Statins | POS edits/RetroDUR | $48,000 | $12,000 |
| Sedative Hypnotics | POS /RetroDUR | $600,000 | $150,000 |
| Supplemental Rebates for AAAX meds | PDL/Supplemental rebate | $6,000,000 | $1,500,000 |
| **Total** | | **$8.0 Million** | **$2.0 Million** |

## Summary

This document points to potential total savings of $8 Million dollars ($2 Million State funds) per year. These recommendations are based on the current pricing, market share, CMS rebate data, and other available information. ACS will work with OMPP's clinical committees to promote these opportunities and defend their clinical and fiscal merits. These interventions are not the universe of all potential savings. ACS will assess and monitor other PDL area with potential savings.

Enhanced interaction and engagement of the members of the DUR Board and T-Committees should assist ACS in the promotion of these opportunities. This interaction should also provide ACS with advanced warnings of any clinical or operational concerns the committee members may have regarding a proposed intervention or program change.

In closing, ACS is a committed business partner of OMPP. The efforts listed in this document and their associated cost-savings figures are believed to be reasonable and achievable. Successful implementation of these efforts and the realization of their associated cost-savings will be a win-win for both ACS and IN Medicaid.

ACS looks forward to your critical review of this document and a follow up discussion. Part of this discussion should include a "next steps" discussion. With agreement as to the initiatives at hand, ACS will work with OMPP to design a mutually agreeable roll out schedule.